**AUTHORIZATION FORM**

This form when completed and signed by you, authorizes me to release/exchange protected information from your clinical record to/by the person(s) you designate.

I _____ authorize: **Scharlemann Klapste, MA, LAMFT**
Scharlemann Klapste, LLC
_____ 5407 Excelsior Blvd, Suite B
St Louis Park, MN 55416
Phone 952-769-7464 Fax 952-920-9323
and/or his or her administrative and clinical staff (cross out if not applicable), to release/exchange this information:

____Initial Assessment/History
____Past and Ongoing Case notes
____Summary of Treatment
____Medical/Lab Results
____Consultation Reports
____All of the above
____Other (specify) _____

____Treatment Plan
____Psychological Testing and Evaluation
____Neurological Testing
____Chemical Dependency Evaluation
____Educational Assessments

(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released and/or exchanged with:

_____(Individual(s)/Clinic)

_____(Address)

_____ (Phone/Fax)

I am requesting my counselor to release/exchange this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

_____At The Request Of The Individual_____

This authorization will expire:
____30 days after termination of treatment
____Upon my written request
(Specify)_____

____Immediately after requested information is received
____Other

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client (Parent/Guardian for Minor) Date

_____ _____
Signature of Client (Parent/Guardian for Minor) Date

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.